



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARK H. HENRY, MD

Respondent Name

TRAVELERS INDEMNITY CO OF CONN

MFDR Tracking Number

M4-17-2595-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

MAY 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code."

Amount in Dispute: \$2,518.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to reimbursement for CPT code 20680 (deep removal of implant). The Provider did not submit any documentation with his billing to substantiate that CPT code 20680 was performed, or that CPT code 20680 is the proper coding for the level of procedure performed as opposed to other codes, such as 20670 (superficial removal of implant). The Provider does not supply an operative report for the alleged surgery. Further, there is nothing in the office visit documentation submitted to substantiate that surgery occurred. The only reference to surgery is for date of service 03-15-2016, when CPT code 26546 was performed. CPT code 26546 is repair of a finer non-union. Even in the 'Surgeon Comments' section, there is no discussion of any surgery, particularly CPT code 20680 which was billed. Therefore, the documentation does not substantiate that CPT code 20680 was actually performed or that it is the correct code versus other coding for similar procedures."

Response Submitted by: William E. Weldon/Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2016	CPT Code 20680 Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	\$2,518.88	\$0.00
	CPT Code 29130 Application of finger splint; static	\$0.00	\$0.00
	CPT Code 15004 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids,	\$0.00	\$0.00

	mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children		
TOTAL		\$2,518.88	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks codes whenever appropriate.
 - W3-Additional payment made on appeal/reconsideration.
 - NDOC-The documentation that was received does not provide enough detailed information to determine the appropriateness of the billed service/procedure.
 - TR64-The medical report does not substantiate the billed charge.
 - 50-These are non-covered services because this is not deemed a 'medical necessity'
 - By the payer.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Does the submitted documentation support billing code 20680-LT? Is the requestor entitled to reimbursement?

Findings

1. According to the original explanation of benefits, the respondent denied reimbursement for CPT code 20680-LT based upon "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer." Upon reconsideration, the respondent did not maintain the medical necessity denial, but denied based upon "16-Claim/service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks codes whenever appropriate", "NDOC-The documentation that was received does not provide enough detailed information to determine the appropriateness of the billed service/procedure", and "TR64-The medical report does not substantiate the billed charge". The division finds that a medical necessity issue does not exist in this dispute.
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
 - CPT code 20680-LT is defined as "Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)."

The respondent contends that reimbursement is not due because "there is nothing in the office visit documentation submitted to substantiate that surgery occurred. The only reference to surgery is for date of service 03-15-2016, when CPT code 26546 was performed. CPT code 26546 is repair of a finer non-union. Even in the 'Surgeon Comments' section, there is no discussion of any surgery, particularly CPT code 20680 which was billed. Therefore, the documentation does not substantiate that CPT code 20680 was actually performed or that it is the correct code versus other coding for similar procedures."

A review of the May 19, 2016 report finds no documentation to support a deep removal of implant. As a result, Code 20680-LT is not supported. The division finds reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>5/25/2017</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.